CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DRUG ENFORCEMENT & PROFESSIONAL PRACTICES BRANCH
275 EAST MAIN STREET, 5ED
FRANKFORT 40621-0001

For Office Use Only
Lic. No._____
Date Rec._____

LICENSE UPDATE FOR A MANUFACTURER OR WHOLESALER OF CONTROLLED SUBSTANCES

Please fill out item 1. Then complete only those items for which changes are being submitted.

1. Name of Licensee: _____

Kentucky Controlled Substance License number: _____

Telephone: _____ Fax: _____

2. Schedule(s) (Check all that apply)

☐ II ☐ IIIN
☐ IIN ☐ IV ☐ KY IV (Nalbuphine)
☐ III ☐ V

☐ 1,4 Butanediol, Gamma-Butyrolactone, GBL, Dihydro-2(3H)-furanone, 1,2-Butanolide, 1,4-Butanolide; 4-Hydroxybutanoic acid lactone, gamma-hydroxybutyric acid lactone (Code of Federal Regulations 21 Part 1310.02 (a)) – Industrial Use Only – Not for human consumption

3. All trade or business names: _____

4. Contact person(s) for the handling, storage or recordkeeping of controlled substances (attach additional pages if necessary):

Name:	Name:
Address:	Address:
Email:	Email:
Phone:	Phone:

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5. Type of ownership:

☐ **Individual/Sole Proprietorship**

_____
Name

_____
Address

☐ **Partnership: (Attach additional pages if necessary)**

_____
Name of Partnership

_____ _____
Name of Partner Name of Partner

_____ _____
Address of Partner Address of Partner

☐ **Limited Liability Company: (Attach additional pages if necessary)**

_____
Name of LLC

_____ _____
Name of Manager or Member Name of Manager or Member

_____ _____
Address of Manager or Member Address of Manager or Member

☐ **Corporation**

_____
Name of Corporation

_____
State of Incorporation

Name_____ Name_____

Title_____ Title_____

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Name_____ Name_____

Title_____ Title_____

Name_____ Name_____

Title_____ Title_____

6. Describe the business, the physical facilities, and the type security provided (Attach additional pages if necessary):

7. DEA number of licensee: _____ Expiration date: _____

8. Has applicant or any partner, officer, director or agent ever been convicted of a misdemeanor involving any controlled substance?
☐ Yes (attach explanation) ☐ No

9. Has any applicant or any partner, officer, director, or agent been convicted of any felony?
☐ Yes (attach explanation) ☐ No

I understand that the Cabinet for Health Services shall be notified in the event of any theft or other loss of controlled substances. Any problem, such as pilferage, which develops in a facility, must also be reported. Assistance may be available if desired.

I hereby certify that all answers given in this application are true, complete and correct and I understand that any license issued to me by the Cabinet for Health Services may be suspended or revoked for cause.

_____

Printed Name & Title of Respondent

_____ _____

Signature Date